

# Documentation of Monthly Nursing Assessment

Consumer Name: \_\_\_\_\_

General / Preventive Health	Y	N		See Comments Below
1) Annual Physical /Vision Exam/ Dental Exam				
2) Preventive screenings				
3) Immunizations are current based on CDC guidelines				
4) Hepatitis B screen or vaccination				
5) TB screening				
<b>Monthly Assessment and Evaluation of Health Status</b>				
1) Review of physician orders and their application				
2) Review of special diet and effectiveness				
3) Medical record contains necessary laboratory test results				
4) Review of adaptive equipment				
5) Change in health condition and needs identified				
6) Vital signs/weight monitored and documented as indicated				
7) Appointments/treatments				
<b>Delegation and Supervision of UAP and Medication Administration</b>				
1) Routine and PRN medications were administered and documented correctly.				
2) Staff know the procedure in the event of a medication error				
3) Periodic review of procedures/skill and technique of staff				
4) Training need identified				
<b>ITEM IDENTIFIED BY AGENCY RN</b>	<b>RECOMMENDATION AND/OR ACTION NEEDED</b>			
1.				
2.				
3.				
4.				
5.				

RN Signature \_\_\_\_\_ Report Date: \_\_\_\_\_ For Month of \_\_\_\_\_

Findings Provided to: ☒ Administrator  
☒ QMRP  
☒ Consumer File